



# Oregon Ear, Nose, and Throat Center Balance Questionnaire

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

I. When you are "dizzy," do you have any of the following sensations?

- No  Yes Lightheadedness
- No  Yes Swimming sensation in the head
- No  Yes Blacking out
- No  Yes Loss of consciousness
- No  Yes Tendency to fall?  
 Left  Right  Forward  Back
- No  Yes Objects spinning around you
- No  Yes You are spinning, while outside objects are stationary
- No  Yes Loss of balance when walking  
Veer to  Left  Right
- No  Yes Headache
- No  Yes Nausea or vomiting
- No  Yes Pressure in the head
- No  Yes Pressure in the ear;  Left  Right  Both

II. Check yes or no, and fill in the blanks.

- No  Yes My dizziness is constant
- No  Yes My dizziness is in attacks  
When did the attacks first occur? \_\_\_\_\_  
How often? \_\_\_\_\_  
How long do they last? \_\_\_\_\_
- No  Yes Do you know the attack is about to start? How? \_\_\_\_\_
- No  Yes Are you free of dizziness between attacks?
- No  Yes Are you dizzy only in certain positions?  
If yes, what positions? \_\_\_\_\_
- No  Yes Do you have trouble walking in the dark?  
Do you know of anything that will:  
 No  Yes Start the dizziness? \_\_\_\_\_  
 No  Yes Stop the dizziness? \_\_\_\_\_  
 No  Yes Make the dizziness worse? \_\_\_\_\_
- No  Yes Were you exposed to fumes, paints, etc. at the onset of dizziness?
- No  Yes Did you ever injure your head?
- No  Yes Have you been knocked unconscious?
- No  Yes Did you ever injure your neck?
- No  Yes Was there a change in your medications when the dizziness began?
- No  Yes Have you had ear surgery?

III. Check yes or no, and fill in the blanks regarding your ears.

- No  Yes Any difficulty hearing?  Left  Right  Both  
When did this start? \_\_\_\_\_  
Is it getting worse? \_\_\_\_\_
- No  Yes Any noise in you ears?  Left  Right  Both  
Describe the noise \_\_\_\_\_
- No  Yes Does the noise change with dizziness?  
If yes, then how? \_\_\_\_\_
- No  Yes Does anything make it better? \_\_\_\_\_
- No  Yes Any fullness in ears?  Left  Right  Both
- No  Yes Does this change when dizzy? \_\_\_\_\_
- No  Yes Pain in ears?  Left  Right  Both
- No  Yes Discharge from ears?  Left  Right  Both

IV. Do you ever experience the following?

- No  Yes Double vision
- No  Yes Numbness in face or extremities
- No  Yes Blurred vision or blindness
- No  Yes Weakness in arms or legs
- No  Yes Clumsiness in arms or legs
- No  Yes Confusion or loss of consciousness
- No  Yes Speech difficulty
- No  Yes Swallowing difficulty
- No  Yes Tingling around mouth
- No  Yes Spots before eyes

V. Does the following apply?

- No  Yes Dizzy after exertion or exercise
- No  Yes New glasses or contacts recently
- No  Yes Get upset easily
- No  Yes Dizzy after not eating for a long time
- No  Yes Dizziness related to menstrual period

The above information is accurate to the best of my knowledge. \_\_\_\_\_  
Patient Signature Date

I have reviewed the above information with the patient. \_\_\_\_\_  
Physician Signature Date

Physician Name (Printed)